Date of last v	risit to a physi	ician:		_ Pı	irpose of Visit:				
Doctor's nam	ne:				none #:()				
Address:		Dhamisian							
vaine of curr	ent personar i	Physician:							
Family			If Deceased,	Age at	Has any blood relative	Encircle			
History	Name:	Age:	Cause of Death	Death	ever had:	No or Yes	Who?		
Father					Alcoholism	No Yes			
Mother					Drug Problems	No Yes			
Brother/s	1.				Depression	No Yes			
Or	2.				Mental Problems	No Yes			
Sister/s	3.				Psychiatric Treatment	No Yes			
~	4.				Epilepsy	No Yes			
Spouse	5.				Neurological Disorder	No Yes			
Children	1.				Suicidal Attempts	No Yes			
	2.								
	3.								
	4. 5.								
M - 3!1			• 6 4 6	4.	11111 / 11	1 4 11	1/1 /1 75 /		
Medical	Please p	lace a check	in front of any q	uestions y	ou would like to discuss i	n more detail	with the Doctor.		
History									
		Circle	V	Jhen was v	our last physical Examinat	ion?			
Have you ev	er had:	No or Ye			eations are you allergic to?				
Rheumatic Fo		No Yes			ver been hospitalized for an				
Epilepsy	CVCI	No Yes		lave you ev	rei been nospitanzed for an	ly major miles	s: specify		
Ephepsy Fuberculosis		No Yes		Then and w	here you hospitalized:				
Vervousness		No Yes			er had an operation? Type				
Mental Probl	em	No Yes			ently have any dental prob				
Arthritis		No Yes			ad any complications from		sease?		
Bone or Joint	t Disease	No Yes	W	hen was y	our last chest x-ray?				
Meningitis		No Yes			our last electrocardiogram				
Gonorrhea or	Syphilis	No Yes	W	hat do you	ı weigh now?				
aundice		No Yes	W	hat was y	our weight one year ago?_				
Γhyroid Dise	ease	No Yes	W	hat was v	our maximum weight and o	date?			
Diabetes		No Yes	Н	as Sleep b	een a problem?				
Cancer		No Yes	Н	as sex bee	n a problem?				
High Blood F	Pressure	No Yes			en a change in appetite?				
Heart Disease		No Yes			ies do you do for fun?				
Asthma		No Yes			o you feel your best?				
Stroke		No Yes			cal complaints, if any do yo				
					· · · · · ·				
What medica	tions do you	take on a regula	ar basis?						
Doctor's Not	es:								
	County of	San Diego		Clion	<b>+•</b>				
Healt		Services Ager	ісу	Chen	Client:				
	Mental Heal	-	•	MR/G	Client ID #:				
				1,114					
MEDICA	LHISTORY	Y QUESTION	NAIRE	D	am:				

HHSA:MHS-911 (12/2001)

History				tor.	
· · · · · · · · · · · · · · · · · · ·	Hava vo	u over he	d any of the following problems		
	e <u>No</u>		Circle	No	Yes
Any eye disease injury, impaired sight		Yes	Night sweats	No	Yes
Any eye disease injury, impaired sight  Any ear disease, injury, impaired hearing		Yes	Shortness of breath	No	Yes
Trouble with nose, sinuses, mouth or throat		Yes	Palpitations or fluttering heart	No	Yes
Head injuries		Yes	Swelling of hands, feet or ankles	No	Yes
Fainting spells		Yes	Back, arm or leg problem	No	Yes
Loss of Consciousness	No	Yes	Varicose veins	No	Yes
Convulsions	No	Yes	Kidney disease or stones	No	Yes
Paralysis	No	Yes	Bladder disease	No	Yes
Dizziness		Yes	Albumin, sugar, pus, blood in urine	No	Yes
Frequent or severe headaches		Yes	Difficulty in urinating	No	Yes
Depression or anxiety		Yes	Abnormal thirst	No	Yes
Difficulty concentrating		Yes	Stomach trouble or ulcer	No	Yes
Memory problems		Yes	Indigestion	No N-	Yes
Extreme tiredness or weakness Hallucinations		Yes Yes	Appendicitis Liver or gallbladder disease	No	Yes Yes
Enlarged glands		Yes	Colitis or other bowel disease	No No	Yes
Enlarged grands Enlarged thyroid or goiter		Yes	Hemorrhoids or rectal bleeding	No	Yes
Skin disease		Yes	Constipation or diarrhea	No	Yes
Chronic or frequent cough		Yes	Crying spells	No	Yes
Chest pain or angina pectoris		Yes	Suicidal thoughts	No	Yes
Coughing up blood		Yes	Loss of appetite	No	Yes
During what Period: When was the last time that you used any dru Have you ever been treated for a drug problem:	g:		How often:		
WOMEN ONLY: Menstrual History Age at onset: Cycle: I	Days (fro	om start to s	when:  Date of last period:		
Age at onset: Cycle: I Duration: Days	Regul	om start to s	tart) Date of last period:		
Age at onset: Cycle: I	Regul	om start to s	tart) Date of last period:		
Age at onset: Cycle: I Duration: Days	Regul	om start to s	tart) Date of last period:		
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History	Regul	om start to s	tart)  Date of last period:  S No  Pain or Cramps: Yes No Age of youngest living child:		
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch When did you serve? t	Regul Misca	om start to s lar:	tart)  Date of last period:  Pain or Cramps: Yes No Age of youngest living child:  Not Applicable   Rank at Discharge		
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch	Regul Misca	om start to s lar:	tart)  Date of last period:  Pain or Cramps: Yes No Age of youngest living child:  Not Applicable   Rank at Discharge		
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch When did you serve? t Type of discharge t	Regul Misca	om start to s lar:	tart)  Date of last period: Pain or Cramps: Yes No Age of youngest living child:  Not Applicable   Rank at Discharge		
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch When did you serve? t Type of discharge Signature.	Regul Misca	om start to s lar:	tart) Date of last period:		
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch t Type of discharge t  Date form Completed: Signatu	Regul Misca	om start to s lar:	tart)  Date of last period: Pain or Cramps: Yes No Age of youngest living child:  Not Applicable   Rank at Discharge		
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Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch When did you serve? t Type of discharge Signatu  Date form Completed: Doctor's Notes and Recommendations:  County of San Diego	Regul Misca	om start to s lar:	tart) Date of last period:  Pain or Cramps: Yes No Age of youngest living child:  Not Applicable   Rank at Discharge  ardian  (Optional)	ate Rev	viewed.
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch When did you serve? t Type of discharge Signatu  Date form Completed: Doctor's Notes and Recommendations:  County of San Diego Health and Human Services Agency	Regul Misca	om start to s lar:	Date of last period:	ate Rev	viewed.
Age at onset: Cycle: I Duration: Days How many pregnancies:  Military History  Branch When did you serve? t Type of discharge Signatu  Date form Completed: Doctor's Notes and Recommendations:  County of San Diego	Regul Misca	om start to s lar:	tart) Date of last period: S No Pain or Cramps: Yes No Age of youngest living child:  Not Applicable Rank at Discharge  Gradian  (Optional)  Physician's Signature & Date of last period: Prove Pain or Cramps: Yes No	ate Rev	viewed.

County of San Diego	Client:	
County of San Diego Health and Human Services Agency Mental Health Services	Client:	
Health and Human Services Agency		